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INFORMATION MEMO FOR AMBASSADOR GEETA PASI, ETHIOPIA

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Catherine Godfrey and Chelsea Solmo

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Pasi,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dual pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from “scaling to close gaps” to “sustaining” epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program

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tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

The expansion of MMD to people affected by conflict in both conflict and non-conflict zones, has meant that even in the setting of significant civil unrest, many individuals were maintained on therapy. This is a major success for the Ethiopian program and understanding the effect of this and quantifying these successes will be critical.

Non conflict zones

Accelerated differentiated service delivery models which provided support for PLH in the setting of COVID-19

Conflict zones

Multimonth dispensing, especially to the Amhara region

Focus on the second and 3rd 95s with improving VL coverage and suppression
TPT coverage and completion

Together with the Government of Ethiopia and civil society leadership we have made tremendous progress together. Ethiopia should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each team is facing. While assessing possible shortfalls in programming arising from COVID-19, overarching challenges still exist.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Ethiopia:

Food insecurity related to both the conflict in the North and drought in the South will be a significant challenge. There have been an estimated 305 million displaced persons in Ethiopia as of September 2021, some of whom will require HIV treatment and prevention services. Quantifying the impact of this mobile population is a challenge, and it is uncertain how it might affect the overall treatment program. Addressing some of these issues will require regional diplomatic efforts that may include multilateral organizations and other resources. In addition, the following challenges must be addressed.

Non conflict zones

Conflict zones

- Pediatric Cascade: although case finding has remained stable despite COVID-19 challenges and the conflict, interruptions in treatment continue to be problematic. Data challenges have made it difficult to entirely quantify the issue, but interruptions remain higher than returns for pediatric age bands. Good progress has been made in scaling MMD for pediatrics, but work remains in Amhara and Oromia. Viral load cover and suppression is critical to successful pediatric treatment.
- As differentiated service delivery expands to different populations including to individuals with advanced HIV disease, community facility linkage will need to be expanded and strengthened. This is particularly important for individuals with advanced HIV disease, for individuals with both infectious and non-infectious comorbidities and for older individuals.
- Return C/ALHIV to care and continue to scale MMD for these individuals. An interagency review should be conducted of OVC program location to ensure alignment of OVC locations with geographic burden of disease
- Restoration of services in Amhara, is of highest priority, this includes the information services, the supply chain and laboratory services
- Population migration and internally displaced people will be a challenge and systems for tracking and identifying this group are needed.
- Food insecurity is a major challenge and it will be important to partner with other humanitarian organizations to address this
- Gender based violence and violence against children are significant issues in the conflict zones and services will need to be tailored to these areas.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Ethiopia is **\$103,900,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Ethiopia and civil society of Ethiopia, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: S/GAC – Chair and PPM, Catherine Godfrey and Chelsea Solmo, PEPFAR Country Coordinator Aimee Rurangwa

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes

1. Ethiopia has demonstrated excellent long-term retention of care in regions that are not affected by conflict. Among those sites that have reported on this indicator, IIT has been well under 2% across most age groups and over multiple quarters. Return to treatment numbers have been similar to IIT numbers for the last few quarters, suggesting stability in the treatment program. However, the highest priority for Ethiopia, including conflict areas, is to identify those who have interrupted treatment and return them to treatment. Tx_Curr has dropped by ~17,000 from quarter 3 to 4, adding to losses from prior quarters in large part due to the civil war. Intensifying the role of the community partners linking clients identified in the community, tracing of clients with IIT and linkage back to health facilities for treatment can contribute to maintaining the TX_CURR. SOPs for community-facility linkages and referrals can be developed by an interagency team.
2. MMD scale up continues to be very successful, with the majority of patients enrolled in MMD, and over half of all patients on 6MMD. However, given the current context, Ethiopia may need to review current MMD practices and consider expanding 6MMD further including to children and to those who may not currently be eligible. Other DSD models could be expanded/adapted to further mitigate treatment interruption, taking lessons from successful interventions, including expanding the role of the community and using faith-based initiatives that have shown success at reducing the treatment interruption.
3. TB screening and TPT completion: Overall, 91% of ART clients have been screened for TB which is the highest percentage achieved in any recent reporting period up from early pandemic proportion of 82%. Ethiopia completed 16,328 TPT in Q4. Ethiopia improved in the number and percentage of specimens sent for diagnostic testing of ART clients who screened positive for TB from 71% in Q2 to 78% in Q4. WHO's change in screening guidance will need to be considered carefully, especially in the context of GeneXpert maintenance issues.

Challenges

1. Pediatric treatment cascade: Despite maintaining pediatric testing and case finding during COVID-19 and conflict, pediatric ART coverage (40%) lags significantly behind adults (81%). Pediatric testing targets and strategies should take into account the current pediatric treatment gap, while maximizing index testing coverage and ensuring robust pediatric OPD testing, using innovative approaches to overcome barriers from COVID-19. Pediatric linkage has been declining. Active linkage strategies should be strengthened, especially the use of accompanied referrals by facility case managers or peer cadres. Linkage of orphans and vulnerable children to case management will help to ensure continuity on treatment. Age-appropriate disclosure and empowerment models of care and treatment for children and adolescents are other strategies that should be adopted. VLS suppression rates remain below 90% for younger children, especially <5-year-olds. All infants at least 4 weeks old and 3kg, children and adolescents should be transitioned to a DTG-based regimen by the end of FY23Q1. Pediatric VL coverage also remains lower in children <5 years. The use of family-centered, clinical approaches to ensure offer of VL, the availability of child-appropriate blood draw supplies, the use of DBS as an alternative sample type where plasma collection is a challenge and point of care VL which allows faster

action on high VL results in children are all examples of activities that will improve viral load suppression rates.

2. Mortality: Reducing HIV associated mortality requires focus on the key priority age groups and on individuals with advanced disease. The advanced disease package of care should be fully integrated into clinical care and includes diagnostics for identifying advanced disease, cotrimoxazole for prophylaxis as well as diagnostics and therapeutics for tuberculosis and cryptococcal meningitis. Sites with the capacity to treat advanced disease, and their ancillary sites should be prioritized. A hub and spoke model may be helpful. Ethiopia should budget adequately for commodities including urinary LF-LAM, CrAg, amphotericin B and flucytosine. To achieve optimal CD4 testing, the country program together with the Ministry of Health should review CD4 testing services and this review should be used to provide optimization of existing CD4 testing services. To reduce mortality in high priority groups (<5, >50) attention should be paid to the pediatric cascade, and to developing differentiated service delivery models for the older adult.

3. Services in conflict zones: The conflict in Ethiopia has caused significant disruption of health and other public services. According to reports coming out from the affected regions, it has resulted in significant destruction and looting of health facilities, internal displacement and loss of health workforce in the region. Support to community systems can play a critical role in revitalizing HIV services and reconstituting the ART cohort in the region. Provision of options to access ART services, tracking clients experiencing treatment interruption and re-engaging them back to treatment, addressing viral load literacy and suppression related challenges in concert with facility-based interventions are critical to this endeavor. It is also of paramount importance for the epidemic control efforts in Tigray and other affected regions to ensure that the highly marginalized key and priority population and OVC in the region are not left out of the revitalizing and cohort reconstituting efforts.

Given your country's status of achieved or near achieving epidemic control, a laser focus on ensuring successful treatment of all PLHIV is needed ensuring continuity of treatment and virologic suppression for individuals of all ages, all geographic regions and all population groups. The following priority strategic and integrated changes are recommended:

1. Returning clients affected by conflict to treatment
2. Investigate viral load testing gaps with a view to reaching >90% cover for all SNU and PSNU, including among pregnant and breast-feeding women.
3. Scale up of DSD models with emphasis on efficiency, addressing gaps identified by close program review including for newer priority populations.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows:
Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	\$ 98,769,989	\$ -	\$ -	\$ -	\$ 400,000	\$ -	\$ -	\$ -	\$ 99,169,989
GHP-State	\$ 95,982,489	\$ -	\$ -		\$ -	\$ -	\$ -		\$ 95,982,489
GHP-USAID	\$ -				\$ 400,000				\$ 400,000
GAP	\$ 2,787,500				\$ -				\$ 2,787,500
Total Applied Pipeline	\$ -	\$ -	\$ -	\$ 4,730,011	\$ -	\$ -	\$ -	\$ -	\$ 4,730,011
DOD				\$ 41,681				\$ -	\$ 41,681
HHS/CDC				\$ 989,373				\$ -	\$ 989,373
USAID				\$ 793,998				\$ -	\$ 793,998
USAID/WCF				\$ 2,742,437				\$ -	\$ 2,742,437
State/AF				\$ 162,522				\$ -	\$ 162,522
TOTAL FUNDING	\$ 98,769,989	\$ -	\$ -	\$ 4,730,011	\$ 400,000	\$ -	\$ -	\$ -	\$ 103,900,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of \$57,772,600 and the full Orphans and Vulnerable Children (OVC) level of \$11,279,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	\$ 57,772,600	\$ -	\$ -	\$ 57,772,600
OVC	\$ 11,279,000	\$ -	\$ -	\$ 11,279,000
GBV	\$ 8,513,400	\$ -	\$ -	\$ 8,513,400
Water	\$ 330,000	\$ -	\$ -	\$ 330,000

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	\$ 103,500,000	\$ 400,000	\$ 103,900,000
Core Program	\$ 89,225,000	\$ -	\$ 89,225,000
Cervical Cancer	\$ 3,260,000	\$ -	\$ 3,260,000
Condoms (GHP-USAID Central Funding)	\$ -	\$ 400,000	\$ 400,000
OVC (Non-DREAMS)	\$ 10,315,000	\$ -	\$ 10,315,000
VMMC	\$ 700,000	\$ -	\$ 700,000

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	\$ 818,700	\$ -	\$ 818,700
PrEP (AGYW)	\$ 300,000	\$ -	\$ 300,000
PrEP (KPs)	\$ 518,700	\$ -	\$ 518,700

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	\$ 118,901

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	13,614	28,772
TX Current 15+	412,747	527,217
VMMC 15+	48,583	25,110
Cervical Cancer Screening	70,259	131,006
TB Preventive Therapy	30,353	50,537

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
Ethiopia	\$116,269,711	\$98,913,029	\$17,356,681
DOD	\$400,000	\$246,425	\$153,575
HHS/CDC	\$67,689,864	\$58,507,742	\$9,182,122
HHS/HRSA	\$200,000	\$180,446	\$19,554
State	\$3,704,781	\$734,487	\$2,970,294
USAID	\$28,423,495	\$25,176,945	\$3,246,550
USAID/WCF	\$15,851,571	\$14,066,984	\$1,784,586
Grand Total	\$116,269,711	\$98,913,029	\$17,356,681

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/C DC	HTS_TST	643,338	2,629,674	408.75%	HTS Program Area	\$7,722,177	47%
	HTS_TST_POS	59,996	27,664	46.11%			
	TX_NEW	79,359	28,826	36.32%	C&T Program Area	\$25,785,055	36%
	TX_CURR	579,216	422,465	72.94%			
	VMMC_CIRC	45,000	45,499	101.11%	VMMC Sub-Program Area	\$727,403	100%
	OVC_SERVICE	N/A	N/A	N/A	OVC Beneficiary	N/A	N/A
DOD	HTS_TST	N/A	3,084	N/A	HTS Program Area	N/A	N/A
	HTS_TST_POS	N/A	1	N/A			
	TX_NEW	N/A	N/A	N/A	C&T Program Area	N/A	N/A
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	3,084	5,000	61.68%	VMMC Sub-Program Area	\$131,433	34%
	OVC_SERVICE	N/A	N/A	N/A	OVC Beneficiary	N/A	N/A
USAID	HTS_TST	136,719	104,711	76.59%	HTS Program Area	\$6,398,196	90%
	HTS_TST_POS	18,509	8,386	45.31%			
	TX_NEW	2,395	2,260	94.36%	C&T Program Area	\$15,250,036	85%
	TX_CURR	3,413	3,896	114.15%			
	VMMC_CIRC	N/A	N/A	N/A	VMMC Sub-Program Area	N/A	N/A
	OVC_SERVICE	348,616	442,484	126.93%	OVC Beneficiary	\$8,374,725	81%
	Above Site Programs					\$12,197,562	
	Program Management					\$13,021,639	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school,

community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. <u>Status:</u> Completed	
2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens. <u>Status:</u> Completed	
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. <u>Status:</u> Completed. Ongoing activities will include greater focus on specific populations.	
4. All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <u>Status:</u> Completed	
5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. <u>Status:</u> In-process <u>Issues or Barriers:</u> Diagnostic network optimization activities are a regular process with the Ethiopian Public Health Institute and other GoE entities. However, there are significant implementation challenges: -Supplies: Ensuring consistent, uninterrupted supplies for VL and EID testing	

<p>-Maintenance: Ensuring regular maintenance of PCR and Gene XPert machines. This is being addressed by moving to an all-inclusive maintenance agreement with manufactures</p> <p>-Specimen referral network: This has largely been successful using the Ethiopian Postal Service. However, some areas remain difficult to reach. This is being addressed through introduction of POC VL in select areas.</p> <p>-Specific populations: VL coverage lags for children, and in some areas, PBFW, especially. This is being addressed by introducing DBS and POC VL for those populations.</p>
Case Finding
<p>6. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p> <p><u>Status</u>: Completed</p>
Prevention and OVC
<p>7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)</p> <p><u>Status</u>: In-process</p> <p><u>Issues or Barriers</u>: Populations eligible for PrEP services in Ethiopia are only seronegative FSW and Discordant couples. Introducing PrEP for additional populations especially adult men engaged in high-risk practices will be critical.</p>
<p>8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p> <p><u>Status</u>: In-process</p> <p><u>Issues or Barriers</u>: The FY21 planned activities have been achieved, and certain activities are continuing in FY22 too. The program is actively facilitating testing for all children at risk of HIV infection. Children at risk of HIV infection are being linked with health facilities for testing, and tested positives are linked for treatment and VL monitoring. IPs are performing case management for OVC comprehensive targeted children. The HIV prevention trainings for adolescent girls and boys aged 1-14 in high HIV-burden areas are being provided to prevent sexual violence and HIV. Significant issues exist in conflict zones, with others, programming needs to be developed for this population.</p>
Policy & Public Health Systems Support
<p>9. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>

<p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> Ethiopia has endorsed U=U at a multi-sectoral level to help reduce stigma and discrimination.</p>
<p>10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.</p> <p><u>Status:</u> Completed</p>
<p>11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p> <p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> The country has adopted this as a standard of care and is part of the national guidelines.</p> <p>All implementing partners (IP) are expected to ensure that all PEPFAR supported sites are implementing infection prevention and control (IPC) interventions; in order to ensure that the services offered are safe to the clients and health care providers. All IPs should have a dedicated IPC person to coordinate and monitor IPC activities across sites supported by the partner. IPs should ensure that there is a site level IPC focal person identified who ensures compliance of IPC implementation at the facilities. All OUs and implementing partners should use the PPE planning tool to ensure availability of sufficient quantities of PPEs as an adjunct to the key IPC interventions. The newly designed IPC SIMS CEEs can be used by the IPs to monitor compliance of IPC implementation at the supported facilities. As facilities are repaired and rebuilt in conflict zones, attention should be given to engineered infection prevention and control solutions.</p>
<p>12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p> <p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> Ethiopia has endorsed U=U at a multi-sectoral level to help reduce stigma and discrimination.</p>
<p>13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses.</p> <p><u>Status:</u> Not started</p> <p><u>Issues or Barriers:</u> CDC supports a local network of PLHIV (NEP+) with direct funding and has been for many years. Their role has not increased, however, in recent years.</p>
<p>14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.</p> <p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> There is evidence of greater government responsibility in the area of oversight, management, and coordination of HIV programs, however, increase of domestic government</p>

<p>funding for HIV programs has been limited. The focus has been on improving budget execution at the national level and identifying where efficiency gains can be made among the stable regions. Emphasize the importance of having the HIV DRMS strategy endorsed by the Council of Ministers and ensure implementation. Endorsing and setting up the implementation of this strategy will take time and prove critical once economic stability occurs.</p>
<p>15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p> <p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> -High reporting rate of PEPFAR MER indicators (TX_ML disaggregates), however limited verification/confirmation capacity.</p> <p>-Currently underway is MOH guidelines on mortality surveillance using verbal autopsy, that PEPFAR/CDC is supporting.</p>
<p>16. Scale-up of case surveillance and unique identifiers for patients across all sites.</p> <p><u>Status:</u> In-process</p> <p><u>Issues or Barriers:</u> GOE has started national ID system with unique ID. This effort is likely to be an important aid to successful surveillance. Until this is fully implemented, cased surveillance and unique identifiers should continue to cover more patients.</p> <p>-Case surveillance has been scaled up as planned except in regions experiencing conflict. Eventual goal is to capture all new HIV cases and integrate with a national PHEM/notifiable disease system.</p> <p>-Case surveillance activities that are being scaled up include individual and community response, longitudinal case surveillance, and adoption of RITA protocol</p>

In addition to meeting the minimum requirements outlined above, it is expected that Ethiopia will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

OU –Specific Directives
HIV Clinical Services
<p>1. Pediatric cascade: (stable and conflict): Pediatric linkage has been declining. Strengthen active linkage strategies such as accompanied referrals by facility case managers or peer cadres, ensure linkage to orphans and vulnerable children case management to ensure continuity on treatment once linked; prioritize age-appropriate disclosure and empowerment models of care and treatment for children and adolescents. Continue to scale VLC for C/ALHIV, improve VLS in children <5. In conflict zones, increase 3+MMD in children.</p>
<p>2. Improve lifespan in high priority groups (<5, >50, those with advanced HIV disease) by focusing on TX_ML and on the commodities needed to diagnose and treat advanced HIV disease.</p>
<p>3. Differentiated service delivery for different populations, including older adults and KP</p>
<p>4. In conflict zones return adults and children w HIV to care; ensuring HCW safety. Ensure access to needed medications including TB meds at distribution centers using forecasting to predict needed supplies</p>

5. Increase numbers of specimens sent for individuals who have a positive TB screen and the use of Xpert technology. Accelerate TB detections by either adding CXR or WHO recommended rapid diagnostic tests to screening algorithm.
HIV Prevention Services
1. Work to change PrEP policies to expand populations eligible. Support DSD for PrEP
2. Improve KP linkage to treatment ART and VL coverage
3. Harmonize M&E tools for KP
4. Scale up both assisted and unassisted HIVST through secondary distribution of HIVST kits using the contacts of index cases such as sexual partners. Expand on the HIVST target populations to include KPs, STI clients and their sexual partners
Other Government Policy, Systems, or Programming Changes Needed
1. Work with others to develop programming for IDPs in conflict zones to specifically include GBV, PEP, and OVC care. Work with others to enhance food security in conflict zones for PLHIV and those at risk for HIV.
2. Ensure all sites are implementing IPC interventions, and that there is a site level focal IPC person at every facility
3. Expand HCST for parent/caretaker delivered HIVST
4. Although PEPFAR DSD supported sites have excellent performance in PMTCT indicators, the national MTCT rate is high (15% in 2020 per SPECTRUM) partially related to insufficient national ART coverage among PW. Regional disparities exist in ART coverage among PW in sub-national units. To the extent possible given the current conflict, continue to strengthen above-site support to the federal government through the PMTCT TWG and the newly formed national validation committee to increase ART coverage among PW in low-performing, non-conflict regions.

In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.

COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and

strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g. DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health

institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- ♦ 100% Care and Treatment (C&T) Program Areas
- ♦ 50% Testing (HTS) Program Areas
- ♦ 100% Above Site Program: Laboratory System Strengthening
- ♦ 70% Pregnant and Breastfeeding Women Beneficiary Group
- ♦ Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries)
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer, DREAMS, OVC (non-DREAMS), and VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts

included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the [PEPFAR Financial Classifications Reference Guide](#).

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20. While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.